
APPLICATION PROCESSING

G-100	Introduction
G-200	General Information
G-300	Application Form
G-400	Time Limits for Disposing of Applications
G-500	Reserved
G-600	Who Can Make Application for Assistance
G-700	Application Date
G-800	Acceptable Application Forms
G-900	Application Interviews
G-1000	Securing Information to Determine Eligibility
G-1100	Cooperation
G-1200	Reserved
G-1300	Obvious Ineligibility
G-1400	Withdrawals
G-1500	Death of Applicant before Certification
G-1600	Securing Disability Decisions (B and D Categories)
G-1700	Reusing the Application Form
G-1800	Reserved
G-1900	Referrals to SSI
G-2000	Decision Notices
G-2100	Retroactive Reimbursement

APPLICATION PROCESSING**G****G-100 INTRODUCTION**

This section contains information on processing medical assistance applications.

Note:

Although the term "applicant" is used in this section, this policy also applies to certified recipients for whom a renewal of eligibility is being completed, as well as to responsible persons acting on behalf of an applicant/recipient.

G-200 GENERAL INFORMATION

The local office is required to:

- Provide adequate physical facilities to receive persons who come to the office, including orderly surroundings and privacy for interviews.
- Receive courteously and promptly all persons who come to or contact the office.
- Allow any individual the right to apply for any kind of benefit, regardless of circumstances.
- Provide an application form to anyone who requests one.
- Determine as soon as possible if the person asking for help is seeking a type of assistance which the agency offers. If not, refer him to another community agency or resource designed to meet his needs, if one is available.
- Communicate in a clear and courteous manner information regarding services offered through the agency. The plan outlined below shall be used for communicating with blind, deaf, illiterate, and non-English speaking applicants.

- Blind Applicant

Explain the various services offered through the agency and answer any questions the applicant may ask. Read forms to the applicant in their entirety and assist in the completion of the forms as needed.

- Deaf Applicant

Secure a person proficient in sign language or communicate in writing to relate an explanation of the programs and to answer any questions, and assist in the application process.

- Illiterate Applicant

Relate the services offered through the agency in simple terms and phrases which the applicant can understand and assist in the application process.

- Language Barrier Applicant

Secure the assistance of an interpreter capable of communicating in the applicant's language to relate the services offered and assist in the application process.

- In circumstances involving applicants with life-threatening health conditions requiring urgent medical care, eligibility staff should expedite the application process with the receipt of the request for medical assistance.

In such urgent situations, the application should be completed as quickly as possible. It would generally not be appropriate to refer the individual to a Medicaid Application Center. Completion of the application could involve a telephone interview, then taking whatever steps are necessary (including a field visit) to obtain a signature on the application. If using the Automated Online Application system, which allows a digital signature to be used when a telephone interview is conducted, a handwritten signature is not required. To the extent possible, these applications should not be transferred to another location for processing, as this could further delay processing. If an expedited application must be transferred to another location for processing, the transfer must be electronic (i.e. by fax, e-mail or input into the electronic case record) or hand-carried. It is never appropriate to mail an application form and/or information for an urgent application to another office for processing.

G-300 APPLICATION FORM

The BHSF Form 1-G can be used for all Medicaid programs except Long Term Care: facility, HCBS (waiver), and PACE.

- BHSF Form 1-CH is acceptable for CHAMP Child, LaCHIP and LaCHIP Affordable Plan.
- BHSF Form 1-MB is acceptable for Medicare Savings Programs (QMB, SLMB, QI).
- BHSF Form 1-PW is acceptable for CHAMP Pregnant Women/LaMoms.
- BHSF Form 1-BCC is acceptable for the Breast and Cervical Cancer Program.
- BHSF Form 1-MPP is acceptable for the Medicaid Purchase Plan.
- BHSF Form 1-FP is acceptable for the TAKE CHARGE Family Planning program.
- BHSF Form 1-FOA is acceptable for the Family Opportunity Act program.
- The BHSF form 1-L, 1-L SSI or 1-LTC SSI is to be used for Long Term Care applications: facility, HCBS (waivers), and PACE.

Exception:

For children in the custody of the state, an OCS application form is used. One of the forms listed above is required to determine the Medicaid eligibility of an OCS child currently certified in Category O.

Note:

It is preferable that forms are used for a specific program. However, if an application is received and in reviewing the eligibility criteria it is determined that a person is eligible for coverage in a program other than the program designated for the form, a determination should be made without requiring a new form except for LTC. Any additional

information needed should be obtained prior to a decision being made.

The application form:

- is the official agency document used to collect information necessary to determine eligibility,
- is the applicant's formal declaration of financial and other circumstances at the time of application,
- is the applicant's certification that all information provided is true and correct,
- shall not be altered after the applicant has signed the form, and
- can be used in a court of law.

G-400 TIME LIMITS FOR DISPOSING OF APPLICATIONS

Ninety days are allowed for the disposition of applications in the disability (D) category if a disability determination by MEDT is required.

Forty-five days are allowed for all other cases.

For an LTC/HCBS applicant who is waiting placement in a facility, allow the application to pend up to 45 days. If the applicant has not entered the facility by the 45th day, reject the LTC application and consider eligibility in other programs such as MNP, MSP and/or MPP.

G-500 RESERVED (Section G-0000 – Application Processing Removed G-500 “Parish of Application” from MEM 9/12/08)**NOTE:**

Refer to the *MVA Eligibility Administrative Procedures Manual* chapter entitled “[Case Transfers](#).” This chapter has been developed (Initial issue date 9/9/2008) to provide statewide standardization regarding the transfer of applications, certified cases due for renewal, and active cases.

G-510 RESERVED (Section G-0000 – Application Processing, removed G-510 “Applicant Who Moves Out of State Before Certification” from MEM 9/12/08)**NOTE:**

Refer to the *MVA Eligibility Administrative Procedures Manual* chapter entitled “[Case Transfers](#).” This chapter has been developed (Initial issue date 9/9/2008) to provide statewide standardization regarding the transfer of applications, certified cases due for renewal, and active cases.

G-600 WHO CAN MAKE APPLICATION FOR ASSISTANCE

Application for assistance may be made by:

- the applicant,
- a parent or legal guardian of a child,
- a curator or other legal representative of an adult,
- a spouse or other responsible person,
- the appropriate OCS/OYD worker for a child in the custody of the state,
- any other person who is acting for the applicant, or
- other agencies to whom the court has awarded custody.

Note:

A LTC facility or HCBS provider may complete an application for an individual although it is not recommended that provider personnel sign the application form as the applicant's representative. Provider personnel who assume such responsibility for the applicant are required to adhere to the requirements established in the "Delegation of Rights" section of the Standards for Payments manual.

G-700 APPLICATION DATE

The application date is the date the signed application is received in the local Medicaid office or in an agency representative's office. This applies to applications taken by telephone, received in person, by mail, by fax or electronically.

A local Medicaid office is defined as :

- a local or regional Medicaid office,
- the LaCHIP Processing Office,
- a MAP Unit, or
- any other Louisiana Medicaid Office, or
- a certified Medicaid Application Center.

Using a Renewal Form as an Application

To reduce procedural closures at renewal and expedite the application process, a renewal form may be used as an application. Two possible situations are outlined below:

1. If an enrollee provides the renewal form anytime after the renewal month, treat this as an application and do not refer the enrollee to an Application Center. The application date is the date the renewal form is received. If more than 30 days have passed since the effective date of closure (effective date being first day of month following closure), contact the enrollee to ensure eligibility factors (particularly income and household composition) are met.
2. The enrollee provides the verification on or prior to cut-off in the month after the renewal month. The analyst reopens the case and makes the eligibility determination, using the previously submitted renewal form and the information provided. The application date is the date the verification is received. Do not refer the client to an Application Center. Verification provided later than the deadline in this situation must be submitted with a new application form since break in eligibility has occurred.

Request for Application

The request for application may be made by:

- applicant,
- family,
- other representative, or
- Long Term Care or HCBS Facility.

Medicaid has the responsibility to process any application request and to make arrangements for completion of the application.

G-800 ACCEPTABLE APPLICATION FORMS

Accept the application form as official if it contains the applicant's name and address and is properly signed. A renewal form can be used as an application form at any time. Do not require the applicant to complete a new application form. Refer to G-1700.

The applicant and spouse must sign unless physically or mentally incompetent or incapable even with an authorized representative. The applicant/recipient shall not have the right to remove him or herself from the eligibility process by the act of approving an authorized representative.

Consider the application form properly signed if it contains:

- the signature of the applicant or the signature of a responsible person or authorized representative if the applicant was unable to sign and the signature of the spouse if included in the income unit,
- the signature of the MUM and the MUM's parent or legal guardian if residing with the MUM, or
- the parent(s) of the child who resides in the home.

Note:

A signature with an "X" mark accompanied by signatures of two witnesses is acceptable.

The application should be completed and signed by the applicant. If he is unable to complete and/or sign the application, document the case record with the reason, and allow the following persons to act:

- for an adult:
 - a spouse or responsible person,
 - a curator or other legal representative, or
 - any other person who is acting for the applicant.

Note:

If the applicant has a legal curator, the curator shall complete and sign the application form.

- for a child:
 - a parent,
 - a qualified relative, or
 - a legal guardian, including a custodial agency (e.g., OCS or OYD).

Note:

If the child resides with both parents, the signature of one parent is acceptable.

If the application is for a child in state custody (OCS/OYD), the application must be completed by:

- the relative if the child has been placed with a relative, or
- a representative of the custodial agency, if the child is in any other placement situation.

Exception:

For a CHAMP or LaChip child, any responsible person with whom the child lives may act for him.

- for LTC applicants only:
 - An employee of the LTC facility may give information for completion of the form, if there is no responsible person, legal guardian or curator.
 - If the applicant is unable to complete the application form and there is no one to act on his behalf, the agency representative

shall sign the application as the person helping to complete the form. Refer to G-810, Applicant Unable to Participate in the Eligibility Determination Process.

- For a deceased applicant refer to G-810 and G-1500.

Note:

It is not recommended that facility personnel, including administrators, be the authorized representatives for applicants. See "Note" at G-600 for requirements.

G-810 APPLICANT UNABLE TO PARTICIPATE IN THE ELIGIBILITY DETERMINATION PROCESS

If the applicant is physically or mentally unable to complete the application form or is deceased and has no one to act for him, complete the form with information received:

- from the applicant, parent, spouse, curator, or legal guardian (a legal guardian is a person who is legally responsible for the care and management of the person or property of one who is considered by law to be incompetent to manage his own affairs),
- from the responsible person (a responsible person is a person trusted or depended upon to assist in the care and management of the person or property of a person who has not been declared incompetent to manage his own affairs),

Note:

If the responsible person refuses or fails to cooperate, help the applicant find another responsible person.

- from a friend or relative, who is not the responsible person,
- from any other person who has information about the applicant's situation and has been designated to act as an authorized representative, or
- by the agency representative's verification and

documentation.

Note:

If the applicant is unable to participate in the eligibility process or when the LTC responsible person fails to keep appointments or provide requested information, it becomes the agency representative's responsibility to assist the applicant in completing the application process. When the applicant is unable to participate obtain and document supervisory approval when assuming this responsibility

G-900 APPLICATION INTERVIEWS**G-910 GENERAL INFORMATION**

Interviews are official and confidential discussions of household circumstances. The agency representative must:

- inform applicants of their rights and responsibilities,
- provide information about program policies and procedures,
- review information that is on the application form,
- evaluate all available information, including what is in the existing case record, and
- explore and resolve any unclear or incomplete information.

Appropriate referrals should be made to other agencies based on needs of the applicant.

G-911 MANAGEMENT

Management is the way the household handles its expenses with available income. Thorough examination of management is a tool to determine the accuracy and completeness of the information the household provides. Examine financial management when needed.

G-911.1 How to Evaluate Management

- Review the case to see if there is enough income to meet the household's expenses. Consider how the applicant pays for food, shelter, utilities, clothing, day-to-day expenses, and all other regular bills. Look for clues which may indicate unreported income or resources.
- Determine if the household has multiple sources of income such as income from tips, commissions, overtime, or bonuses.

- When a household borrows money from friends or relatives, determine if the loans are valid, if the applicant intends to repay the loan, and when repayment will begin.
- Determine if a household's expenses are paid directly by another source, such as HUD rental assistance, the Salvation Army, insurance, or another person outside the household.
- Determine whether information given in the past is consistent with the current situation and if reliable assumptions for future periods can be made based on the information.
- Determine if any bills are unpaid, when the applicant last paid these bills, and when he expects to pay them again.
- Evaluate facts such as age, education, disability, and former sources of income for potential current income.
- Explore potential sources of income and resources for each person.

G-911.2 Sources of Verification

At the point the recipient cannot explain management the situation becomes questionable and may require verification. Verify any questionable information which affects eligibility. Sources may include LDOL clearances, collateral contacts, copies of paid or unpaid bills, contacts with former employers or absent parents, or any other source which can verify the recipient's situation.

Request from the recipient any verification needed that he can reasonably provide. Give the recipient a written notice of the specific verifications required and the date the information is due, allowing at least 10 calendar days.

G-911.3 Documentation Requirements

Document in the case record the discussion of management and how questionable information was verified.

G-911.4 Case Action

Management review is an interviewing tool, not an eligibility factor. Do not deny benefits simply because expenses exceed income. Consider reasonable explanations. Do not deny benefits because of questionable or inconsistent information, unless defined as refusal to cooperate. Deny benefits or close the case when the applicant fails to provide verification or refuses to cooperate in providing verification. Refer to G-1100 thru G-1140, Cooperation, for exceptions.

G-920 INTERVIEWS

A face-to-face interview is not required. A telephone interview is allowed.

Conduct the interviews with:

- the applicant,
- the curator, if the applicant is interdicted,
- the parent(s) living in the home if the applicant is a minor,
- the applicant and her parent if the applicant is a MUM or PUM,
- the person requesting assistance for a CHAMP child applicant, or
- an individual designated as the applicant's authorized representative.

If the applicant is unable to be interviewed, wishes to have a responsible person, or authorized representative interviewed, document the reason given by the applicant and conduct the interview with the responsible person/authorized representative.

Note:

A curator or legal guardian is the legal representative of an individual. Interview the curator or guardian instead of the

applicant. If the applicant is legally competent, interview him when possible.

When completing ex parte renewals on non-SSI cases or cases without an active Food Stamp certification, a telephone contact is required to verify residence.

When the applicant or parent of a minor applicant is unable to be interviewed, the following persons may be interviewed:

- a curator or other legal representative of an adult,
- a responsible person, or
- any other person who is acting for the applicant and has been designated as an authorized representative.

Note:

Interview the MUM or PUM if her parent is not present. Conduct a telephone interview with the parent, if possible.

If an LTC interview cannot be conducted, refer to G-810, Applicant Unable to Participate in the Eligibility Process.

G-930 INTERVIEW SITES

If a face-to-face interview is needed or requested, conduct it at the local office or an application center, if possible.

If not possible, conduct the interview at a site that is:

- adequate to preserve the privacy and confidentiality of the interview, and
- convenient to both the applicant and the agency representative.

Sites may include:

- the applicant's home,
- a hospital, or

- an LTC facility.

G-940 REQUIRED INTERVIEW EXPLANATIONS

During the application interview, certain explanations must be made using terms that the applicant can understand.

Explain:

- the applicant's responsibility to provide information that is true and correct to the best of his knowledge,
- the applicant's responsibility to cooperate in the eligibility determination,
- the applicant's responsibility to report all changes which may affect eligibility,
- the legal penalties for withholding information or giving false information,
- that the applicant's SSN will be matched against files of the SSA, IRS and Louisiana Department of Employment and Training,
- the agency's policy of confidentiality,
- the agency's policy of nondiscrimination and equal delivery of services,
- the programs available through the agency,
- KIDMED to all applicants and SSI recipients at initial contact whose certification may include an individual under age 21 and/or a pregnant woman,
- the WIC program to all applicants who are pregnant women, postpartum women (until 6 months after a pregnancy ends), breastfeeding women (until the baby's first birthday), or families with infants and children up to age five.
- the agency's responsibility for implementing policy in determining eligibility, including the responsibility to

verify and document the eligibility decision made,

- the agency time limits for disposing of applications,
- the applicant's right to an agency conference or a fair hearing (Refer to OFS Chapter 7), and
- assignment of rights to medical support and third party resources.

G-1000 SECURING INFORMATION TO DETERMINE ELIGIBILITY

Secure essential information for determining eligibility.

For applications processed by a Qualified Provider, send copies of all correspondence and notices mailed or given to the applicant to the Qualified Provider.

Consider the applicant as the primary source of information. The act of appointing an authorized representative does not change or lessen the applicant/recipient's responsibility to provide complete and correct information on the application form.

The applicant/recipient/responsible person or authorized representative is required to:

- make an effort to obtain all information needed to determine eligibility,
- authorize the obtaining of documents from third parties,
- answer all eligibility related questions to the best of his knowledge,
- report any changes that may affect eligibility, and
- appear for required interviews.

If the applicant cannot furnish all required verifications during the interview and indicates that he can later provide the needed information:

- agree upon a reasonable time period for providing the information, allowing at least 10 days,
- make a list of the items or actions needed with the deadline for submittal specified,
- sign the agreement and secure the applicant's signature on the agreement, and
- give the applicant a copy.

If the applicant indicates that he is unable to obtain the needed information, assist him in obtaining the information:

- by use of consent forms signed by the applicant to request verification directly from collateral sources,
- by review of existing case record(s) (Request any case record from other parishes where the applicant applied for or received assistance), and
- by requesting assistance from other parishes, such as searching court records, or from other agencies.

In situations involving a life-threatening health condition requiring urgent medical care, the Medicaid Analyst should expedite the application process, taking special steps to obtain any required verifications, including a field visit, if necessary. Refer to I-514.2 Local Office Decision for more information relative to the MEDT package.

G-1100 COOPERATION

The agency representative has a responsibility to decide whether an applicant is capable of participating in the eligibility process. Refer to G-810.

For all applicants who are incapable of cooperation because of physical and/or mental condition, the application shall not be rejected for failure to cooperate.

G-1110 COOPERATION BY PHYSICALLY AND MENTALLY ABLE APPLICANTS

The applicant must cooperate in the process of determining eligibility by completing an application form, being interviewed, and providing required information. Refer to G-1130.

The agency representative shall:

- allow adequate time for the applicant/recipient to receive notice of the interview and make arrangements to attend,
- inform the applicant in writing of what is required and the consequences of not cooperating,
- allow at least 10 days for the applicant to provide the information or advise the agency representative that he is unable to secure the requested information, and
- assist the applicant to obtain the needed information or identify and secure alternate information.

Do not ask the applicant to provide information which is clearly impossible for him to secure. If the agency representative has fulfilled his responsibilities, but the applicant fails or refuses to provide information he agreed to provide which is necessary to complete the eligibility determination process, take action to deny the application or close the case using adverse action procedures.

If the applicant fails to keep his scheduled application appointment and does not contact the office by the close of business on the appointment date, deny the application the next working day. If the applicant does not provide the information by the date noted on the

agreement form and does not contact the agency, deny the application on the following day. Refer to G-1140.

G-1120 COOPERATION BY LTC AND OTHER APPLICANTS UNABLE TO PARTICIPATE

For applicants unable to participate in the eligibility determination process, refer to G-810 for alternatives. Other methods to use are visits to the applicant at home, in the hospital, or in the LTC facility and personal or telephone contact with any of the applicant's relatives, friends, hospital or other medical provider staff who can supply needed information.

G-1130 LTC REFUSAL TO COOPERATE

The application may be rejected only if the applicant, parent or legal guardian:

- is physically and mentally able to make application and provide information,
- has been notified of the need to provide information,
- has been advised of the consequences of not cooperating, and
- has refused to do so.

Do not reject an application for refusal to cooperate if the responsible person refuses to cooperate. In this case, assist the applicant in finding another responsible person. If none can be located, refer to G-810 or G-1120.

G-1140 FAILURE TO COOPERATE

It is the agency's responsibility to pursue the eligibility determination through the decision, unless the applicant/recipient refuses to cooperate. Refer to G-1130, LTC Refusal to Cooperate.

Before denying eligibility for failure to cooperate, review the case record to determine the following:

- that the applicant/recipient/responsible person is physically and mentally able to meet responsibilities,
- that adequate time was given to provide the information or evidence,
- that the applicant/recipient was given enough notice to have been able to make arrangements to attend the interview (if there is any doubt, schedule another interview),
- that the request for information was clear, in writing, and dated,
- that the applicant/recipient/responsible person was informed of the responsibility for providing and consequences for not providing information, and
- that the applicant/recipient is not claiming good cause for failure to cooperate in pursuing a responsible third party. Refer to Assignment of Rights, I-200.

G-1150 SECOND CONTACT SITUATIONS

Second Contacts are needed in these situations:

- When a Qualified Provider (e.g. Health Unit) has interviewed an applicant and requested information by a set date, call the Qualified Provider and allow an additional ten days for the applicant to supply the requested information.
- When a patient in an acute care hospital is interviewed by a MAP Unit Medicaid Analyst, he is given 10 days to provide requested information. If the information is not provided, a final notice is sent to the applicant with an additional 10 days given for the applicant to supply the requested information. If the information is not received, the application cannot be rejected until the 45th or 60th day.
- If the agency representative cannot judge the applicant's capability, contact the applicant or responsible person prior to rejecting the application for:

- failure to cooperate in supplying requested data,
- refusal to comply with agency regulations, or
- failure to keep an appointment without contacting to reschedule.

If after the second contact, the applicant or responsible person does not comply with the above, reject the application the day after the date of noncompliance.

G-1200 RESERVED

G-1300 OBVIOUS INELIGIBILITY

Reject the application at any point during the eligibility determination that enough information is obtained and recorded to establish ineligibility.

- If the applicant gives information on the application form or in the interview that establishes that he does not meet an eligibility factor, explain that his application will be rejected without any further investigation.
- If the information is received after the initial interview, contact the applicant to establish that the information is correct. If correct explain that his application will be rejected and send the appropriate notice of rejection.

If ineligibility is based on resources, determine whether the applicant is also income ineligible.

- If the applicant is only resource ineligible, the rejection notice shall advise the applicant to reapply when resources are reduced below the limit and/or inform the applicant of policy regarding transfer of resources. Refer to I-1400 through I-1600 for resource eligibility.
- If the applicant is also income ineligible, the rejection notice shall advise the applicant that he is both income and resource ineligible.

Prior to rejection of any application, consider eligibility in all other Medicaid programs.

Note:

Do not advise the applicant/recipient to dispose of resources or how to dispose of the resources.

G-1400 WITHDRAWALS

An applicant may voluntarily withdraw his application or request closure of his case at any point in the eligibility process. Withdrawals should not be confused with rejections. Rejections can be initiated by the agency whenever ineligibility has been established and should not be documented as withdrawals. Withdrawals are client-initiated. A withdrawal must not be suggested or solicited by staff. Whenever ineligibility is established reject the application using the appropriate reason. Do not reject the application as a withdrawal. When an applicant contacts the Agency to withdraw or request closure of his application/certification:

- obtain a signed statement in the applicant or responsible person's own words giving the reason for withdrawal/closure,
- obtain supervisory approval to process a withdrawal/closure,
- document the case record with the reason for withdrawal/closure, and
- send a rejection notice which states the reason given for the withdrawal/closure.

Exception:

A written statement is not required if the Agency initiates contact with the household during the renewal process and is advised by the household that they do not intend to complete the renewal process.

Note:

If the applicant refuses to sign a statement of withdrawal, document the case record and obtain supervisory approval. The rejection notice shall state the applicant requested withdrawal but refused to sign a statement.

The "withdrawal" or "requested closure" codes shall not be used to avoid the Medicaid Roll-Down procedure or in place of the appropriate rejection code during the Roll-Down procedure.

G-1500 DEATH OF APPLICANT BEFORE CERTIFICATION

If the applicant dies before certification and eligibility is established, certify the case. Eligibility cannot extend beyond the date of death.

An eligibility determination can be made even if the applicant dies before signing the application form. If there is no one to act for the deceased applicant, complete the application form with information received:

- from any person who has information about the applicant's situation, or
- by agency representative verification and documentation. The agency representative shall obtain sufficient evidence to support the decision.

Note:

A medical provider shall not be allowed to sign the application form.

A disability decision is required for deceased applicants for the period of assistance requested, if application is in category D and the applicant did not receive RSDI disability benefits.

G-1600 SECURING DISABILITY DECISIONS FOR B AND D CATEGORIES

Refer to Category (Blind, E-220 and Disabled, E-240) and Eligibility Factors (Requirements Related to SSI Eligibility Status, Application for SSI, I-2110).

If the applicant has not already been determined disabled by SSA, submit MEDT package with complete medical and social information.

G-1610 DISABILITY DECISIONS

Louisiana Medicaid's Medical Eligibility Determination Team (MEDT) determines categorical eligibility for disability based on medical criteria established by the Social Security Administration (SSA) under Section 1634 of the Social Security Act. An SSA/SSI disability decision takes precedence over any contrary state disability determination. An MEDT decision should not be requested when the individual receives SSA or SSI Disability benefits or Medicare.

An MEDT decision on disability should not be requested if the individual is otherwise ineligible

All Medicaid applications or renewals, including those for nursing facilities or waiver services programs, based on disability require submission of a complete MEDT package unless there is an existing MEDT approval which would cover the certification period. For instructions refer to:

<http://bhsfonlinemanuals/mfm/medt%20instructions.pdf>

The Medicaid Analyst is expected to take special steps to obtain any required medical documentation for the package. In situations involving life-threatening health conditions requiring urgent care, requests for Medicaid decisions should be marked "New-Urgent".

G-1610.1 MEDT Package:

MEDT packages consist of a current Form MEDT with the following:

- Social information on Form MS for all adult decisions, or Form MS/C, if a child;
- Medical information on Forms MD or MR;

- Medical documentation obtained from physicians, medical facilities, etc;
- All previous Forms MEDT;
- Period of coverage requested.

G-1610.2 MEDT Decision Required

A MEDT decision is required if:

- a disability decision has not been rendered by SSA;
- SSA has rendered an unfavorable disability decision and:
 - medical documentation is available to demonstrate the deterioration of the applicant's medical condition since the SSA denial
 - a new medical condition can be documented,
 - the applicant is appealing the SSA determination, or
 - the applicant is employed and applying for Medicaid Purchase Plan.
- Retroactive Eligibility is requested
- Applicant has been diagnosed as or is suspected of being infected with tuberculosis and is not eligible in category A, B, or D.

G-1610.3 MEDT Decision Not Required

A MEDT decision is not required if:

- a favorable SSA decision has been rendered for disability or Medicare which covers the requested period of Medicaid eligibility, or

- the applicant is otherwise ineligible
 - do not reject for failure to meet disability if the applicant is also ineligible for another reason,
- or, the applicant has lost SSDI/SSI for a reason other than cessation of disability and a favorable SSA disability decision has been made within the 12 prior months.

G-1610.4 MEDT Approval

If the applicant is otherwise eligible, certify, and set renewal date for the same month the Form MEDT is to be resubmitted if within the allowed renewal time frame.

The MEDT decision remains in effect even if the case is closed and later recertified unless there has been an improvement in the recipient's condition.

If there has been an improvement in the recipient's condition, submit Form MEDT prior to the due date.

A subsequent adverse disability decision made by SSA/SSI, that is not timely appealed, takes precedence over the MEDT decision.

Exception:

Submit Form MEDT for re-evaluation of the agency's disability determination if a subsequent adverse disability decision by SSA is made for a MPP recipient.

G-1610.5 MEDT Denial

Reject the application or close the case upon receipt of the MEDT decision. If applicable, issue Advance Notice of Closure.

G-1610.6 Reconsideration of MEDT Denial

A request for reconsideration of the MEDT decision should be

completed if:

- new medical or social information is obtained, or
- during the BHSF Appeals process, additional medical documentation is available which supports the deterioration of the applicant/recipient's condition, or
- a new medical condition can be documented

G-1610.7 Resubmit to MEDT

Resubmit a complete MEDT package:

- if the MEDT decision does not include the needed period of coverage, i.e., retroactive,
- for a different categorical decision requiring MEDT approval,
- at renewal,
- at renewal for a case certified or continued based on a Bureau of Appeals decision, or
- if there are changes in the case which require approval by MEDT for continuance.

Verbal approval will not be provided.

G-1610.8 Reapplication after MEDT Denial

If the applicant reapplies within 90 days from the date of a previous Form MEDT denial, reject the Medicaid application unless there has been:

- a significant deterioration of the applicant's medical condition, or
- a new medical condition can be documented.

Include on the Form MS, or MS/C the applicant's statement regarding the change in his medical condition since the last MEDT denial.

G-1610.9 Requesting Authorization for Medical Exam

The worker should first determine if medical documentation is available from a licensed physician, clinic, hospital, Disability Determination Services (DDS), LA Rehabilitation Services (LRS), other sources, or a free source.

If medical documentation is not available for a MEDT decision, a request for authorization of a medical exam should be included on the Form MEDT.

If authorization is approved, the worker shall request a written report from the physician regarding the applicant's medical condition. Use Form MR-A to authorize payment for the examination in accordance with instructions. The written report shall be included as part of the complete MEDT packet. **

G-1610.10 SSA Certifies Applicant for SSI

Upon receipt of documentation that SSA has certified the applicant for SSI:

- certify for Medicaid (manually or through SDX process),
- certify for LTC retroactively to the date of SSI eligibility if the applicant:
 - was a resident of an LTC facility and
 - met all other eligibility factors, (refer to Eligibility Determination, LTC, H-800), or
- make appropriate case changes, if the case was certified based on the Form MEDT approval.

G-1610.11 SSA Denials

If SSA has denied the applicant's/recipient's SSI application based on disability in the last 12 months and the applicant is not appealing the SSA denial:

- reject the application, or

- initiate closure action, if the case was certified based on the Form MEDT approval. Refer to Changes, L-0000.

Exception:

Submit or re-submit a MEDT packet for a MPP disability determination if the applicant or recipient is employed.

G-1610.12 SSI Appeals**Pending Application Disability-Related Medicaid**

Request an MEDT decision if SSA has denied the application based on disability in the last 12 months and the applicant provides documentation that the SSA determination has been timely appealed. Submit or re-submit an MEDT packet for a MPP disability determination if the applicant or recipient is employed.

Certified Disability-Related Medicaid Case

If an individual receiving Medicaid based upon disability is determined by SSA not to be disabled under the SSI standard and the individual provides documentation that the SSA determination has been timely appealed, continue Medicaid coverage until the final determination of disability has been made by SSA. Submit an on-line query or contact the local SSA office requesting notice of appeal decision.

Follow-up with Social Security Administration is required every 90 days.

G-1610.13 Significant Deterioration in Medical Condition after SSA Denial

If the applicant has been denied based on disability within the 12 months prior to the Medicaid application, reject the Medicaid application unless:

- an SSI appeal is in process and applicant's income is above the FBR.
- a significant deterioration in medical condition can be documented, or

- a new medical condition can be documented, or
- the applicant is employed and is applying for Medicaid Purchase Plan (MPP) coverage.

Include the applicant's statement regarding the change in his medical condition since the denial on the Form MS, or MS/C. Give the applicant 10 days to provide additional medical information that can show a change in their medical condition before submitting Form MEDT.

G-1615 RESERVED

G-1620 SIMPLIFIED DISABILITY DECISIONS FOR INFANTS

Louisiana allows a simplified determination of disability based on minimal evidence on premature or low birth weight infants and/or those infants with an allegation or diagnosis of Down syndrome, even if no other medical impairments exist.

A simplified disability decision for infants always begins on the date of birth and extends until the child reaches the age of one year (date of birth through the 12th month).

Continuing eligibility for Medicaid must be explored whenever there are changes in the child's circumstances that affect eligibility or once the simplified disability period ends. Another MEDT decision will be required for an ongoing disability decision. A review of all current medical evidence must be completed.

G-1620.1 MEDT Package:

MEDT will make the simplified disability decision for infants. Submit a MEDT package consisting of a current Form MEDT requesting a simplified disability decision with a birth certificate or other evidence (e.g., the hospital admission summary, physician or other medical professional's statement) that shows:

1. A weight below 1200 grams (2 pounds, 10 ounces) at birth or

2. A gestational age (age from conception to birth) at birth as specified in the bulleted list below with the corresponding birth-weight indicated:
 - If the gestational age is 37- 40 weeks and the weight at birth is less than 2000 grams (4 pounds, 6 ounces);
 - If the gestational age is 36 weeks and the weight at birth is less than 1875 grams (4 pounds , 2 ounces);
 - If the gestational age is 35 weeks and the weight at birth is less than 1700 grams (3 pounds, 12 ounces);
 - If the gestational age is 34 weeks and the weight at birth is less than 1500 grams (3 pounds, 5 ounces);
 - If the gestational age is 33 weeks and the weight at birth is at least 1200 grams, but no more than 1325 grams (2 pounds, 15 ounces); or
3. An allegation or diagnosis of Down syndrome

Note:

Down syndrome is usually characterized by developmental delays or mental disabilities, and by abnormal physical findings such as characteristic facial features; generalized low muscle tone; short arms and legs; and hands and feet that tend to be broad and flat. Roughly half of persons with Down syndrome will have congenital heart disease.

G-1700 REUSING THE APPLICATION FORM

An application form may be reused to open a new application only in the following situations:

- to reopen an application rejected in error, and
- to reopen an MNP Spend-down case when there is no break in quarters of coverage.

REUSING THE RENEWAL FORM

A renewal form may be used as an application form only in the following situations:

- The recipient submits the form after closure in the month of renewal but before cut-off. Reopen the case and process as a renewal.
- The recipient submits the form after closure in the month of renewal but after cut-off. The application date is the date the renewal form is received by the agency.
- The recipient submits verification after case closure in the month of renewal for failure to provide verification. Reopen the case and process the renewal using the previously submitted form.
- The recipient submits verification on or prior to cut-off in the month after the month of renewal, after case closure for failure to provide verification. The application date is the date the verification is received by the agency.

Note:

Verification provided after this deadline must be submitted with a new application form since there has been a break in eligibility.

Applications Rejected in Error

Use the previous application date as the date of application when reopening an application rejected in error.

Update the application and interview the applicant, in person or by telephone, as necessary.

MNP Spend-down

The MNP application form is valid for up to 12 months from the date of application as long as there is no break in quarters of coverage. Refer to H-1011, Spend-down.

G-1800 Reserved

G-1900 REFFERALS TO SSI

Application for SSI is not a requirement for eligibility in any Medicaid Program. However, applicants/recipients who appear to be eligible for SSI cash shall be advised to contact SSA for application.

If the applicant/recipient applies for SSI, the parish office will be notified by SDX of SSI certification or denial.

Scenarios for general Medicaid applications: (See Z-400 for FBR amounts)

Individuals with/without spouse	Income and resources below FBR. Referral for SSI required.
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Individuals with/without spouse	Income below FBR but resources above SSI resource limit. Ineligible for SSI and Medicaid. Do not refer to SSI.
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Couple	If both members of a couple are applying and their countable couple income falls below couple FBR and couple resource limit, referral for SSI required.
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Scenarios for LTC applications: (See Z-400 for FBR amounts)

LTC applicant w/o community spouse	Applicant's income and resources below FBR. Referral for SSI required.
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LTC applicant w/o community spouse	Applicant's income below individual FBR, but resources exceed individual limit. Do not refer to SSI.
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LTC applicant w/community spouse	Applicant's income below individual FBR. Resources in applicant's name exceed SSI individual limit and/or countable couple resources exceed the individual resource limit. Do not refer for SSI. Explain the spousal
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	impoverishment resource provisions and the allowance under Medicaid LTC Program for transfers to the community spouse. Referral for SSI may be appropriate at renewal.
LTC applicant w/community spouse	Applicant's income below individual FBR and countable couple resources below individual SSI resource limit. Referral for SSI required.
LTC Couple	If both members of a couple are applying, consider income eligibility separately as individuals. If either has income below individual FBR, refer only that member for SSI.

Scenarios for HCBS Waiver applications: (See Z-400 for FBR amounts)

HCBS applicant, no spouse	Income and resources below individual FBR. Referral for SSI required.
HCBS applicant, no spouse	Income below individual FBR, but resources exceed limit. Do not refer for SSI.
HCBS applicant w/spouse	Applicant's income (including deemed income from ineligible spouse) and resources fall below individual FBR. Referral for SSI required.
HCBS applicant w/spouse	Income is below FBR, but resources exceed individual limit. Do not refer for SSI. Explain the spousal impoverishment resource provision and the allowance under Medicaid LTC/HCBS Program for transfers to the community spouse.

G-2000 DECISION NOTICES

Send the eligibility decision notice to the applicant upon disposition of the application.

For limited certifications (e.g., deceased applicant, complete retroactive certifications, MNP spend-down) the notice of certification may also serve as the closure notice.

CHAMP

Send a copy of the CHAMP decision notice to the Qualified Provider who referred the applicant.

WIC

Send Flyer-WIC with the notice of decision for every certification which includes pregnant women, postpartum women (until 6 months after a pregnancy ends), and families with children under age five.

LTC Only

Send a notice of the eligibility decision to:

- the applicant/authorized representative,
- the LTC facility

HCBS Only

Send a notice of eligibility decision to:

- the applicant,
- the HCBS provider, and
- BCSS

G-2100 RETROACTIVE REIMBURSEMENT

The BLANCHARD, ET AL V. FORREST court judgment requires the agency to reimburse the Medicaid enrollee certified on or after February 15, 1995 for part or all of any medical expenses paid by them beginning three months prior to the month of application through receipt of the initial Medical Eligibility Card (MEC).

To qualify for reimbursement, the following criteria must be met:

- 1) The enrollee was Medicaid eligible for the date of service.
- 2) The agency has verified that the provider was an enrolled Medicaid provider on the date the enrollee received service.
- 3) The bills must be for the period beginning three months prior to the month of application through receipt of the initial MEC or reactivation of the MEC. Reactivation of the MEC would take place when an enrollee of Medicaid status has an interruption in coverage, reapplies and is certified for coverage in a qualifying Medicaid program, the certification period is usually twelve months.
- 4) The enrollee has not received reimbursement from Medicaid, the Medicaid provider or received payment in full by a third party entity.
- 5) The medical bills must be for medical care, services or supplies covered by the program at the time the service was delivered.
- 6) The enrollee must provide proof of payment to BHSF. Bills which were paid in full by a third party (such as Medicare, an insurance company, charitable organization, family or friend) cannot be considered for reimbursement unless the enrollee remains liable to the third party. It is a requirement that continuing liability of the enrollee be verified.

Bills Not Eligible for Reimbursement

- Unpaid bills – refer the enrollee to the service provider with instructions to present the MEC to the provider for billing purposes.
- Bills paid by the enrollee after receipt of the initial

MEC or reactivation of the MEC.

- Bills paid to a non-Medicaid provider who does not participate in the Medicaid Program.

The local office shall issue BHSF Form 1-RRP which is a part of the decision notice for all enrollees determined eligible for a period prior upon issuance of the initial MEC or reactivation of the MEC. The enrollee is given 30 days to contact Medicaid to request consideration for reimbursement.

Effective 6/6/05, the MMIS Retroactive Reimbursement Unit is responsible for processing retroactive reimbursement requests. Field staff should refer all retroactive reimbursement requests to the MMIS Retroactive Reimbursement Unit for processing. The following procedure should be followed:

- Scan and file all documentation directly into the financial eligibility case record; and
- Send an e-mail to the MMIS Claims Processing/Recipient Reimbursement Unit at medrrp@la.gov letting them know that there is a new request in the financial eligibility case record. The case name and social security number should be included for identification purposes.

Note: If information is scanned into ECR and an e-mail is sent to medrrp@dhh.la.gov, do not send a duplicate "hard copy" through the mail.

The mailing address is:

**DHH/MMIS/Retroactive Reimbursement Unit
P.O. Box 91030
Baton Rouge, LA 70821-9030**

MMIS Retroactive Reimbursement Unit Responsibilities

If it appears that the enrollee may be eligible for reimbursement, the DHH/MMIS/Retroactive Reimbursement Unit staff will request that the enrollee provide the following to them:

1. A copy of the bill(s) or other acceptable verification which documents:

- Medicaid enrollee's name;
 - for doctor and hospital services; the date(s) of service, procedure and diagnosis codes, number of units provided, amount billed, amount paid, and verification of any private insurance payments;
 - for pharmacy services: date filled, National Drug Code, quantity dispensed, number of units provided, amount billed, amount paid, and verification of any private insurance payments;
 - for Durable Medical Equipment: date(s) of service, quantity, number of units provided, diagnosis and procedural codes, documentation of medical necessity from the doctor, amount billed, amount paid, and verification of any private insurance payments;
 - for dental services: date(s) of service, diagnosis and procedure codes per tooth, number of units provided (adults limited to dentures or oral surgery services only), amount billed, amount paid and verification of private insurance payments; and
 - proof of any payment made by a third party (such as Medicare, an insurance company, charitable organization, family or friend) towards the bill.
2. Receipt(s) or other acceptable proof showing that the bill was paid by the Medicaid enrollee or someone else. If paid by someone else, proof that the eligible is still liable for repayment to the individual who paid the bill.

BHSF Form RRP-V shall be used to request this information. The enrollee shall be allowed 15 days to provide the requested documentation, and upon request for additional time, given an extension. If an extension is requested, no more than 15 additional days will be granted. Enrollees who fail to provide the requested documentation or fail to request an extension shall have the request for reimbursement denied using BHSF Form 18-RRP.

Upon receipt of information from the enrollee, the MMIS Retroactive Reimbursement Unit shall determine if the criteria to qualify for reimbursement has been met. Reimbursements are made at the Medicaid rate, less any Third Party payments.

If all criteria are met, a reimbursement check will be issued to the payee at the Medicaid maximum allowable amount, along with BHSF Form 18-RRP explaining the reimbursement decision.

If all criteria are not met, using BHSF Form 18-RRP, the enrollee shall be advised that eligibility for reimbursement has not been established. The enrollee shall be given a clear and concise explanation of the reason(s) for ineligibility for reimbursement.

The enrollee will be notified of the final decision using BHSF Form 18-RRP which will contain a detailed explanation of all payment and/or denial information.

The MMIS Recipient Reimbursement Unit will file the agency's copies of all forms and documentation to support reimbursement in the Medicaid enrollee's financial eligibility case record.